



Benefits Enrollment / Change Form

New Hire Enrollment

Open Enrollment

Plan Year: \_\_\_\_\_

Qualifying Event

Event Date \_\_\_\_\_

Reason:  Marriage  Adoption  Birth  Legal Guardianship  Divorce

Other: \_\_\_\_\_

Employee Information

WKU ID, Last Name, First Name/MI, SSN, Address, City, State, Zip, Telephone, Annual Salary, Date of Hire, Date of Birth, Occupation, Sex, Marital Status

Medical/Dental Benefit Options

Medical/Vision (Group #: 00070542) options: Blue Access High, Standard, Economy. Dental (Group #: 666530) options: Core, Premier. Elect, Waive, Change options for both.

Dependent Information (Check all that apply)

Table with columns: Medical/Vision, Dental, Name, SSN, DOB, Sex (M/F), Relationship, Drop, Add.

Life Insurance Options

Policy #: 40989, Benefit Group or Class: All Full Time Employees. Coverage Amount Elected: \$15,000. Includes sections for Optional Life, Dependent Life, and Spousal Life.

**Life Insurance Beneficiary Information**

Name	Address	SSN	Relationship	Beneficiary Designation (Must equal 100%)			
				Primary %	Contingent %	Basic Life	Optional Life
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>

**Disability Options**

	WKU Paid	Decline	Drop	Add
<b>Long-Term Disability Plan</b> - The university provides Long-Term Disability at no cost for all full-time employees after a 90 day elimination period for qualified disabilities. The policy will pay 60% of monthly salary up to \$5,000 monthly maximum.	<input checked="" type="checkbox"/>			
<b>Short-Term Disability</b> - The university offers its employees the opportunity to purchase a Short-Term Disability policy through Sun Life which consists of 60% of weekly salary up to a maximum of \$1,250 per week for a maximum benefit period of 13 weeks. Deductions are post-tax. (Please see your benefits representative for rate schedule.) Faculty are covered under a separate leave policy.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Flexible Spending Reimbursement Account**

I authorize a contribution to be made to my **Health Care Reimbursement Account** and/or my **Dependent Care Reimbursement Account**:

- The maximum contribution amount for my healthcare flexible spending account is \$4,000 per year. This amount can be used to pay for eligible health, dental, and vision care for me and my dependents. The maximum contribution amount for my voluntary dependent care account is \$5,000 per year. This can only be used for the care of eligible dependents, which include children under the age of 13 whom are claimed as dependents on my federal tax returns or any other dependent who is mentally or physically disabled and spend at least eight hours in my home each day.
- I understand that the amount(s) I elect will be deducted from my pay on a pre-tax basis in equal amounts throughout the course of the plan year based on my pay frequency.
- In addition, I authorize the FSA vendor to initiate credit entries to my bank account. I understand that this authorization will allow said Vendor to debit my bank account if funds are credited erroneously to my account. This authority is to remain in effect until revoked by me in writing and until the Vendor actually receives such notice of termination. The Vendor will make the necessary changes within 10 business days of receipt of such notice of termination.

Health Care Waiver Account	Health Care Voluntary Account	Dependent Care Voluntary Account
Are you waiving the WKU health care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason for Waiving Coverage: _____	Do you elect to participate: <input type="checkbox"/> Yes <input type="checkbox"/> No  Annual Election Amount \$ _____	Do you elect to participate: <input type="checkbox"/> Yes <input type="checkbox"/> No  Annual Election Amount \$ _____

I hereby authorize Western Kentucky University to deduct from my earnings the appropriate amount or to make the necessary changes and/or adjustments as indicated on this form, with regard to my choices for group benefits, and to remit any deduction to the appropriate Insurance Company or Benefit Plan. All qualified premiums will be deducted on a pre-tax basis unless otherwise noted in writing to the Department of HR. I understand by my participation in these plans that:

- I may not change or stop my contribution during the plan year unless my family or employment status changes (i.e. marriage, divorce, death of a
- In addition, I understand that the effective date for beneficiary changes made by me will be effective on the date I signed this form.
- IRS rules require that any amount not used for covered expenses under my Health Care or Dependent Care Reimbursement Account cannot be returned to me. I understand that I have until March 31 of each year to submit claims incurred during the prior year. I also understand that any change made to my election as the result of a qualifying event cannot be used to cover expenses incurred prior to the qualifying event.
- In the event I do not elect STD or optional life insurance coverage(s) at the time of eligibility or if I elect and later decide to drop coverage, I understand that I will be required to furnish medical evidence of insurability at my own expense, and the insurance company will have the right to refuse my request for coverage.
- I have received and read all written materials provided to me describing the plans, and agree to the terms of participation set forth in the written materials.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**For Human Resources Use Only**

Date Received: _____	
Date Processed: _____	Processed By: _____
Date Effective: _____	